OFFICIAL FILE COPY

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:	2. STATE:
0 2 — 0 1 2	Arkansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

July 1, 2002

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 CFR Part 447.272	a. FFY __2002__ $ __none__ b. FFY __2003__ $ __none__

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):
Attachment 4.19-D, Appendix I, Page 2-8	Attachment 4.19-D, Appendix I, Page 2-8 TN 01-29

10. SUBJECT OF AMENDMENT:

Amends the payment method for the Arkansas Health Center Nursing Facility from rates by level of care to a single rate.

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
13. TYPED NAME: Ray Hanley	Division of Medical Services P.O. Box 1437, Slot S295 Little Rock, AR 72203-1437 Attn: Binnie Alberius
14. TITLE: Director, Division of Medical Service	
15. DATE SUBMITTED: April 22, 2002	

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17. DATE RECEIVED: 24 APRIL 2002	18. DATE APPROVED: 05 JUNE 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 01 JULY 2002	20. SIGNATURE OF REGIONAL OFFICIAL: Diane Murphy, Acting for Calvin Cline
21. TYPED NAME: CALVIN G. CLINE	22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR DIV OF MEDICAID AND STATE OPERATIONS

23. REMARKS: